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Partnership for the Community Management of
Child Health/Partenariat pour la prise en charge
communautaire de la santé infantile (PRISE-C)

Benin, Health Zones of
Allada/Ze/Toffo (AZT)
Dassa/Glazoue (DAGLA)
Save/Ouesse (SAO)

Center for Human Services

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Abbreviations and Acronyms

ACT	Artemisinin-based Combination Therapy
ARI	Acute Respiratory Infection
AZT	Allada/Zè/Toffo Health Zone
BCC	Behavior Change Communication
CEID	Centre d'Expertise d'Ingénierie pour le Développement Durable
CHS	Center for Human Services
CHW	Community Health Worker
CI	Confidence Interval
CPD	Community Participative Diagnosis
CRS	Catholic Relief Services
CVS	Village Health Committee
DAGLA	Dassa/Glazoue Health Zone
DDS	Departmental Health Directorate
DIP	Detailed Implementation Plan
DSME	Mother and Child Health Department
EBF	Exclusive Breast Feeding
HZ	Health Zone
IBFAN	International Baby Food Action Network
IMCI	Integrated Management of Childhood Illnesses
KPC	Knowledge, Practices and Coverage
MCHIP	Maternal Child Health Integrated Program
NGO	Nongovernmental organization
OR	Operations Research
PIHI	Operation plan for National scale-up of high impact interventions
PISAF	Integrated Family Health Project
PRISE-C	Partnership for the Community Management of Child Health
PROMUSAF	Promotion des Mutuelles de Santé en Afrique
RAS	Réseau Alliance Santé
SAO	Save/Ouessè Health Zone
SPPS	Health Protection and Promotion Service
SSF	Family Health Service
SSIO	Nursing and Obstetrical Care Service
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

In 2010, the Center for Human Services (CHS) signed a Cooperative Agreement with USAID to implement the Partnership for the Community Management of Child Health (PRISE-C) in three health zones of two departments in Benin: Allada/Zè/Toffo (AZT) in the Department of Atlantique and Save/Ouesse (SAO) and Dassa/Glazoué (DAGLA) in the Department of Collines. PRISE-C seeks to improve the health of mothers and children in a partnership with the Benin Ministry of Health and its decentralized structures and in close cooperation with the communities, local NGOs, and other implementing organizations. The project will last four years, from 2010 to 2014.

The goals of the project are:

- i) to increase community engagement with the community health system;
- ii) to increase demand for curative and preventive services; and
- iii) to strengthen the performance and sustainability of community-based health services.

Activities support Benin's health policy for decentralization and community health systems, and the USAID strategic objective for health: creating a supportive implementation environment, increasing access to quality services and products; and increasing demand for health services, products, and preventive measures. PRISE-C's activities build off of more than 10 years of implementation of community activities in Benin by URC/CHS, and specifically off of the experiences of the past 5 years with the USAID funded Projet Intégré de Santé Familiale (PISAF) in the Departments of Zou and Collines.

This document reports on the activities and results of the first year of implementation.

PRINCIPAL ACTIVITIES

Project Startup

➤ **Actively engaged key stakeholders for community maternal and child health**

PRISE-C is a community health project which requires the active engagement of key stakeholders at the community level for successful implementation. Our first project activities involved identification of key stakeholders for community maternal and child health, inviting these stakeholders to information sessions on the project and pilot testing the project messages with them, in order to engage them on the key issues from the beginning. In addition to the key project messages, the project objectives, strategies, and principal activities of the project were also introduced. A total of 184 participants attended these information sessions. Between November 2010 and January 2011, the project managers arranged several of these meetings with actors at different levels:

- In each of the seven communes served by the project there was a presentation to key community stakeholders, including opinion leaders, community groups, and community health workers.

- In the three health zones the project was discussed with 48 members of the zone executive committees. These are the coordinating physicians, head physicians, nurses and zone midwives, community activities managers, social workers, a few managers of women's groups and associations, and representatives of partners who work in these health zones.
- In the central level Ministry of Health and partners the project was introduced to the members of the Mother and Child Health Service, the community health unit, and the minister's cabinet. One member represented the WHO at this meeting.
- In the two departmental health departments, the project was discussed with the departmental health directors (DDS), the managers of the Family Health Service (SSF), the Health Protection and Promotion Service (SPPS), the Nursing and Obstetrical Care Service (SSIO), and the prefect of Atlantique/Littoral and Zou/Collines.

During this initial activity, these stakeholders showed clear interest in the project and committed themselves to participating in implementation. Specific commitments made include:

- *Mayoral support*: Incorporating mayoral support to the project in the project budget
- *Health Center Staff*: Ensuring the availability of drugs and where possible, ensuring integration of project activities with health center activities and *incorporating* their commitment to supervising and overseeing project activities into health center budgets
- *District leaders*: Securing the commitment of district leaders to the project and availability of essential drugs at the community level
- *Women's groups*: Committed to ensuring community mobilization by disseminating best practices in the management of childhood illness through their activities
- *Traditional leaders and other key opinion leaders*: Committed to mobilizing their communities in support of project objectives

➤ **Established zonal project teams for project monitoring**

In each health zone, a project activity monitoring team has been established. Each team is comprised of the health zone coordinating physician, the zone midwife, the accountant, and the zone MOH focal point for community health activities. This team is in charge of integrating the project activities into the health zone action plan and monitoring them in the field. In each commune, the head nurses in the arrondissements that have community health workers are the community facilitators/supervisors, who provide on-the-ground monitoring and support to this team. PRISE-C will work through these zonal project teams to ensure integration of project activities in zonal activity plans and budgets.

➤ **Conducted baseline survey**

In order collect the baseline data for project monitoring indicators, a Knowledge, Practices and Coverage (KPC) survey was conducted in the project area. This descriptive cross-cutting survey was conducted with mothers of children from 0 to 23 months old and it took place from January 14-24, 2011 in the three health zones. The WHO two-stage 30 cluster sampling method was used

to identify respondents. Eighteen data collectors, including health care workers and sociologists, were enlisted and trained in data collection techniques. Nine hundred mothers were surveyed in 90 villages.

The results were presented and discussed in the communes in March in meetings led by PRISE-C staff together with the departmental health directors and the health zone coordinating physicians. These same results were presented to national-level Ministry of Health officials in June.

The principal findings of the baseline survey, the Rapid-CATCH indicators, are in Annex 5.

➤ **Prepared Detailed Implementation Plan (DIP)**

Initial community-level discussions for the preparation of the DIP were based on the presentation of the results of the KPC survey to the communities. Community stakeholders provided important contributions on activities to be included in the workplan, based on the survey findings and the root causes of those findings. With this community input, the project workplan was developed and then presented and discussed with MOH officials at national, departmental and zonal level for their input. Project activities were also discussed with other implementing partners working in the same geographic areas in order to coordinate and harmonize activities.

The detailed implementation plan (DIP) was submitted in April 2011 electronically and was presented in person to USAID and MCHIP in Washington DC on July 15, 2011. After certain modifications were suggested by USAID and MCHIP, the revised DIP was submitted and approved in August 2011 pending a few corrections. The final version of the DIP was approved on September 19, 2011.

Intermediate Result 1: Increase Community Engagement with the Community Health Delivery System

➤ **Engaged key community stakeholders in project planning**

As described earlier, the project was introduced to communities in the project area and key community stakeholders committed to supporting the project objectives. In particular, the women's groups and traditional leader of the communities showed their engagement through:

- Commitment to ensure community mobilization by disseminating best practices in the management of childhood illness through their activities (Women's Groups)
- Commitment to mobilize their communities in order to support project objectives (Traditional leaders and other key opinion leaders)

➤ **Community participative diagnosis and annual village action plans**

Head nurses at health facilities, who are also the community health worker (CHW) supervisors, from each health zone received orientation over three days on the community participative diagnosis (CPD) approach. This approach focuses on facilitating a village-level dialogue on priority problems, their root causes and possible solutions. The main purpose of the training is to have a cadre of trained facilitators who can guide this participative diagnosis of health issues in

the villages with the ultimate goal of setting up village health committees and preparing village action plans. Forty one supervisors were trained.

After the initial orientation, the head nurses initiated CPD activities in each of the 118 villages covered by the project. The activity will take place in three stages as follows:

1. Identify and prioritize the village's health issues;
2. Search for the deeply rooted causes and possible solutions; and then
3. Propose actions to be carried out that will be written into the village action plan.

The village action plans will be vetted by the wider community before being finalized. Once final, implementation of activities detailed in the plan will be the responsibility of the village health committee and the CHW, and will be routinely followed up by the commune and zonal health officials, as well as PRISE-C staff.

CPD and village action plan development will continue into October due to the interferences caused by the measles mass vaccination campaign in progress in the country. All action plans should be available by late October 2011.

PRISE-C technical staff carried out monitoring visits in AZT, SAO and DAGLA health zones in September. Actual startup of the CPD process had begun in some villages.

Intermediate Result 2: Increase Demand for Community Preventive and Curative Services

➤ Development and start-up of a project BCC strategy

The results of PRISE-C's baseline KPC survey showed that very few mothers in the project area (31.1%) know their local Community Health Worker (CHW). Practice of ideal health behaviors is low with only 24.3% of new mothers practicing exclusive breastfeeding (EBF), and only 61.8% of children 12-23 months have received a measles vaccination. Nutrition indicators show only 39.3% of infants and young children age 6-23 months are fed according to a minimum of appropriate feeding practices.

Increasing the practice of ideal health behaviors and also community demand for services requires that communities have knowledge of the health services which are available at community level and the role of the community health worker. Community-level communication activities are necessary to change behavior so that mothers and families adopt attitudes, behaviors and practices which will improve maternal and child health. PRISE-C has developed a behavior change communication strategy document which is based on the content of the communication strategy of the Ministry of Health, lessons learned from past experiences, and on the results of the baseline survey. 60 women groups and other resource persons have been identified to assist in the on-the-ground implementation of this strategy.

In addition to the development of the project BCC strategy, certain activities included in the strategy have started. For example, an agreement has been made with the MOH community health activity focal person in the AZT health zone to broadcast maternal and child health messages over the local radio station. Similar agreements with the focal persons in the Collines Department are forthcoming.

➤ **Identified BCC field agents for the SAO and DAGLA health zones**

BCC field agents will be placed in the SAO and DAGLA health zones in order to provide consistent, on-the-ground support on BCC and other activities to CHWs and their supervisors. The profile for the BCC field agents was developed by PRISE-C staff. The Chief Medical Officer of each zone was enlisted to disseminate the information about the position and collect appropriate documentation from the applicants. URC-CHS hiring procedures are being followed in the identification and engagement of the two agents, who will start work in October.

Intermediate Result 3: Strengthen performance and sustainability of the community health delivery system

➤ **Trained community health workers in the SAO and DAGLA Health Zones**

The training process started with a Training of Trainers session. The coordinating physicians, head physicians, and head nurses of all health centers with community health workers in the two health zones of SAO and DAGLA (22 in total) were trained as CHW trainers. The training took place over six days and was led by the managers from the Mother and Child Health Service of the Ministry of Health.

Then, in turn, these trainers trained forty-five (45) community health workers from the two health zones on the complete CHW activity package. The group of CHWs was trained in two groups, with each training lasting six days. This activity took place in March 2011.

From September 26 to 30, 2011, another group of community health workers from the SAO and DAGLA HZs were trained on the community IMCI approach. Forty five (45) community health workers participated in this training. 2 of the CHWs included in this training were replacements for CHWs initially trained earlier in the year.

The purpose of this training was to give the CHWs the skills and tools:

- to teach families and their communities key practices that foster survival and the harmonious development of children; and
- to understand the problems of sick children so that they are immediately providing all necessary care to prevent deaths, and/or to provide necessary treatment.

Training included the following four modules:

- i) communication techniques;
- ii) integrated management of fever, diarrhea, acute respiratory infections (ARIs), and malnutrition in children under five (5) years old;
- iii) monitoring pregnant women, new mothers and newborns; and
- iv) management tools.

PRISE-C staff made a concerted effort to work with communities to identify equal numbers of female and male CHWs when they were identifying new CHWs, and work towards gender equity in the numbers of CHWs trained. Out of the 88 total CHWs in place in SAO and DAGLA, 35 are women and 53 are men.

➤ **Post-training follow-up and supervision of CHWs**

In May 2011, six weeks after the initial SAO and DAGLA training, on-site post training follow-up was provided. Some but not all of the community health workers had already begun activities. Together with the CHWs, PRISE-C staff and local MOH officials identified barriers to the initiation of activities and developed plans to resolve them, so that the CHWs could begin activities as soon as possible.

➤ **Provision of medicines to CHWs**

Between May and October of 2011, the Global Fund distributed 13,440 plackets of ACTs for community based treatment of malaria to CHWs working in our intervention area in the Department of Collines. CHWs receive other medicines and supplies for their kits from their local health facility. CHWs and health facility staff also participated in the national mosquito net distribution campaign, which distributed 77,316 mosquito nets in the three intervention zones.

➤ **Trained the trainers/supervisors of the community health workers in integrated case management in the AZT Health Zone**

The training for the trainers/supervisors of the community health workers in the AZT Health Zone was held from September 26 to 30, 2011, with eleven (11) head physicians and head nurses in attendance.

The purpose of this training was to give the participants the knowledge, skills and tools necessary to train and supervise the community health workers in the complete package of activities. Participants were trained on the content of the community IMCI package as well as the teaching methods to be used for training the health workers so that they understand and effectively manage the health of children and their mothers at the community level.

STATUS OF PROJECT ACTIVITIES

Table 1: Year one activity progress

Intermediate result	Activities	Activity status	Comments
Project startup	Present the project to the health authorities	Done	
	Provide orientation to the project team and prepare the action plan	Done	
	Provide orientation to the commune, zone and ministry teams	Done	
	Prepare the workplan and harmonize it with the health zone plans	Done	

	Implement the baseline survey	Done	
	Analyze and draw up the survey report	Done	
	Share the survey results with the ministry and health actors	Done	
	Prepare the DIP with the partners and health representatives	Done	
	Finalize the training and supervision schedule	Done	
	Hold quarterly meetings with the USAID mission	Done	
IR 1. Increase community engagement with the community health delivery system	Provide orientation to the zone technical management teams and community facilitators in community participatory assessment	Done	
	Prepare the annual village action plans	In progress	
IR 2. Increase demand for community preventive and curative services	Adapt the behavior change strategy papers with the ministry and PISAF based on the outcomes of the baseline survey	In progress	
	Identify and train the BCC workers for the SAO and DAGLA health zones	Done	
	Work together with the local partners to harmonize radio messages about mother and child health	In progress	Not all partners were available, some discussions initiated
	Work together with the community-based health insurance schemes (mutuelles) to identify the key messages for mothers on key child health practices infantile	In progress	Discussed with community leaders to raise awareness of the services the mutuelles offer
	Work with local women's theater groups to educate mothers on key practices for children's health	Not done	Postponed until the next quarter
IR 3. Strengthen	Prepare the facilitator and	Done	

performance and sustainability of the community health delivery system	community health worker training module		
	Retrain the supervisors of the community health workers in IMCI supervision	Not done	Postponed until the quarter 1 of FY2012
	Train the trainers of the community health workers in integrated case management in the AZT HZs	Done	
	Train the DAGLA and SAO HZ community health workers in integrated case management	Done	

FACTORS THAT MAY INTERFERE WITH ACHIEVEMENT OF OBJECTIVES

The main factors that interfered with achieving the objectives in the first year were around coordination of activities. Activities are carried out jointly with the actors in the field, such as staff from the Ministry of Health, the departmental health directorates, and the health zone teams. These staff members are frequently involved in other activities, and this causes some delays in terms of scheduling and implementing PRISE-C activities on the desired date(s).

In addition, the limited financial resources of the project have been stretched very thin proven insufficient to meet the requirements of the directives from the Ministry of Health and the actors in the field. The actors in the field often prefer to place priority on other activities with higher per diem rates. The political commitment and community engagement developed in the initial phases of the project have facilitated the participation of required officials during the first year of activities. The support from the Ministry of Health through the DSME and the Zou/Collines and Atlantique/Littoral DDSs was crucial, as was the support from community leaders for the work of the community health workers, the village health committees, and the health care workers in PRISE-C activities.

TECHNICAL ASSISTANCE

During the first year of the project technical assistance from headquarters was required for several key start-up activities, such as for baseline survey implementation and for preparing the budget and DIP. To this end, the project field team obtained support from:

- Waverly Rennie for baseline survey implementation and BCC
- Sara Riese for preparing the DIP and Operations Research Concept Paper

For assistance with setting up and monitoring the community activities, Centre d'Expertise et d'Ingénierie pour le Développement Durable (CEID) our subcontractor has supported these activities. CEID will continue to provide support to project management for organizing and supervising community activities throughout the duration of the project.

SUBSTANTIVE CHANGES

After the analysis of the baseline survey data, the first draft of the Detailed Implementation Plan (DIP) was prepared and presented to USAID and MCHIP, and we received valuable feedback for improvement. Based on this feedback, the intermediate results that were initially adopted were reviewed and the number was increased from two to three. In addition there were minor changes to the key indicators and the level of effort to be provided in each technical area based on the results of the KPC survey.

Moreover, the innovation topic for operations research, initially intended to be a test of different incentive models for community health workers, was reviewed and redirected to test the collaborative approach at community level as a system to motivate and retain community health workers.

These different changes were taken into account in the final version of the DIP and the operations research concept paper.

COOPERATION WITH LOCAL ORGANIZATIONS

PRISE-C has collaborated with a number of local organizations in its first year. These include: Centre d'Expertise et d'Ingénierie pour le Développement Durable (CEID), RAS, PROMUSAF, International Baby Food Action Network (IBFAN), AFRICARE, and CRS.

CEID is a consulting firm that works in community health. Their subagreement with CHS Benin for PRISE-C includes the following:

- Setting up the community structures and the persons who work on the project: the zone teams, village health committees, communal focal points and BCC workers; and
- Organizing and monitoring community health worker activities in the field.

In this first year, CEID took part in the presentation of the project in the seven communes. It also organized the establishment of the zonal project activity monitoring teams and training and monitoring for the community based participatory diagnosis and annual village action planning activities. PRISE-C staff worked closely during project start-up with CEID's financial and administrative staff to build their capacity and ensure adherence to USAID guidelines.

With the RAS and PROMUSAF mutuelle networks, consultation meetings were held to discuss implementation of mutuelle promotional activities in the PRISE-C project areas. Project presentation activities in the health zones and communes were carried out with the officials from these NGOs.

As part of World Breastfeeding Week, PRISE-C staff worked with IBFAN and took part in a televised debate on breastfeeding and child survival. This cooperation will continue with mobilization activities to raise awareness of mothers in the PRISE-C health zones on the importance of exclusive breastfeeding.

AFRICARE is a nongovernmental organization (NGO) that has received Global Fund funding to set up community health workers who are trained exclusively in treating uncomplicated malaria

in children. AFRICARE works in the two health zones in Collines in which PRISE-C is active, SAO and DAGLA.

Through extensive discussions, PRISE-C has worked with AFRICARE to harmonize activities in the villages in which both organizations operate. To prevent any duplication of efforts, a memorandum of understanding was proposed with AFRICARE. It stipulates that:

- PRISE-C will use AFRICARE community health workers, in addition to non-AFRICARE community health workers, in which these two organizations operate;
- The AFRICARE community health workers will benefit from training in the complete CHW activities package provided by PRISE-C.

Catholic Relief Services (CRS) also received Global Fund funding for malaria activities in the PRISE-C project zone of AZT. PRISE-C sought to establish the same cooperation with CRS as with AFRICARE, however, this agreement has not yet been possible because CRS prefers to have their community health workers continue to exclusively treat malaria. Nonetheless, CRS agreed that PRISE-C could use its community health worker groups for health promotion and education activities in AZT.

COOPERATION WITH THE USAID MISSION

In its first year, PRISE-C worked closely with the USAID mission in Benin, seeking guidance on overarching project goals and objectives. The mission also provided invaluable input during the development of the DIP and OR concept paper. The PRISE-C director has attended several meetings with USAID, including the quarterly partner meetings.

ANNEX 1: MONITORING AND EVALUATION TABLE

First round of complete data collection on these indicators expected Q1 FY 2012.

Objective / Result	No.	Indicator	Rapid Catch Indicator	Numerator	Denominator	Frequency	Baseline Value	Target
1. Increased community engagement with community health delivery system	Village Health Development Committee							
	1	Number of villages with a complete (3 member) village health development committee	NO	NA	NA	Annual	Pending	80
	2	Number of villages with a health workplan	NO	NA	NA	Annual	Pending	80
	3	% of villages with community representation at at least 75% of monthly CHW meetings	NO	Number of villages which are represented by a member of the VHDC at least 75% of monthly CHW supervision meetings	Total number of villages with a PRISE-C CHW	Quarterly	0%	100%
2. Increased demand for high impact community preventive and curative services	Household knowledge and practice							
	4	% of children age 0-5 months who were exclusively breastfed during the last 24 hours	YES	Number of children 0-5 months who drank breastmilk in the previous 24 hours AND did not drink any other liquids in the previous 24 hours AND were not given any other foods or liquids in the previous 24 hours	Total number of children 0-5 months in the survey	Baseline/Endline	25%	50%
	5	% of infants from 0-6 months who are exclusively breastfed	NO	Number of infants from 0-6 months exclusively breast-fed	Number of infants from 0-6 months estimated in the period	Quarterly	Pending	
	6	% of mothers ages 0-23 months who can name two danger signs (pregnancy, newborn or post-partum)	NO	Number of mothers/ guardians of children who know at least 2 danger signs	Number of mothers/ guardians of children interviewed by the health agent	Quarterly	Pending	

Objective / Result	No.	Indicator	Rapid Catch Indicator	Numerator	Denominator	Frequency	Baseline Value	Target
	7	% of newborns seen by a health worker at least 2 times in their first week of life (1-3 days and 3-7 days)	NO	Number of newborns who were seen by a health worker at least 2 times in the first week of life (between the 1st and 3rd and the 3rd and 7th days)	Number of newborns estimated in the period	Quarterly	Pending	
	8	% of children 6-59 months monitored for acute malnutrition	NO	Number of children 6-59 months monitored for acute malnutrition	Number of children 6-59 months estimated to have acute malnutrition	Quarterly	Pending	
	9	% of children ages 0-23 months with diarrhea in the last two weeks who were treated with ORS	YES	Number of children 0-23 months with diarrhea in the last 2 weeks AND who received ORS	Total number of children aged 0-23 months who had diarrhea in the last 2 weeks	Baseline/Endline	39%	60%
	10	% of children ages 0-23 months with diarrhea in the last two weeks who were treated with ORS and zinc supplements	NO	Number of children 0-23 months with diarrhea in the last 2 weeks AND who received zinc supplements	Total number of children aged 0-23 months who had diarrhea in the last 2 weeks	Baseline/Endline	39%	50%
	11	% of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at a hand washing station	YES	Number of mothers with children 0-23 months who live in households with soap at the place for washing hands	Total number of mothers of children age 0-23 months in the survey	Baseline/Endline	12%	50%
	12	% of households with a handwashing station at/near latrines	NO	Number of households with a handwashing point at/near the latrines	Number of households in the catchment area with latrines	Quarterly	Pending	

Objective / Result	No.	Indicator	Rapid Catch Indicator	Numerator	Denominator	Frequency	Baseline Value	Target
	13	% of households who drink water from a pump or who treat their drinking water with Aquatabs	NO	Number of households who have drank water at least once from a pump or who treated their drinking water with Aquatabs at least one in the trimester	Number of households in the catchment area	Quarterly and Baseline/Endline	33%	50%
	14	% of children aged 0-23 months who present with symptoms of pneumonia in the past 2 weeks and who received a front-line antibiotic (CTX) from a health worker or CHW	NO	Number of children aged 0-23 months who present with symptoms of pneumonia in the past 2 weeks and who received a front-line antibiotic (CTX) from a health worker or CHW	Number of children aged 0-23 months who present with symptoms of pneumonia in the past 2 weeks	Baseline/Endline	45%	75%
	15	% of children age 0-23 who slept under a treated mosquito net the night before survey	YES	Number of children aged 0-23 months who slept under an insecticide-treated bednet the previous night	Total number of children age 0-23 months in the survey	Baseline/Endline	79%	90%
	16	% of children in the catchment area from 0-59 months who sleep under an LLIN	NO	Number of children from 0- 59 months who sleep under an LLIN	Number of children from 0-59 months in the CHW catchment area	Quarterly	Pending	
	17	% of children ages 0-23 with fever in the past two weeks who received ACT within 24 hours of onset of fever	YES	Number of children age 0-23 months with a febrile episode in the last 2 weeks AND whose mother/caretaker sought treatment for the child within 24 hours AND who were treated with an appropriate anti-malarial drug	Total number of children age 0-23 months with a febrile episode in the last 2 weeks	Baseline/Endline	35%	50%
	18	% of mothers of children ages 0-23 months who received two IPTs during last pregnancy	NO	Number of mothers of children ages 0-23 months who received two doses of IPT during their last pregnancy	Total number of mothers of children ages 0-23 months in the survey	Baseline/Endline	46%	60%

Objective / Result	No.	Indicator	Rapid Catch Indicator	Numerator	Denominator	Frequency	Baseline Value	Target
	19	% of children who received VitA in the last 6 months	YES	Number of children age 6-23 months who received a dose of Vitamin A in the last 6 months (mothers recall or card verified)	Total number of children age 6-23 months in the survey	Baseline/Endline	82%	95%
	20	% of mothers of children ages 0-23 who had at least 4 ANC visits when they were pregnant with their youngest child	YES	Number of mothers with children age 0-23 months who had at least 4 antenatal visits while pregnant with their youngest child	Total number of mothers of children age 0-23 months in the survey	Baseline/Endline	42%	80%
	21	% of mothers of children ages 0-23 months who had at least 2 VAT before the birth of their youngest child	YES	Number of mothers with children age 0-23 months who received at least 2 tetanus toxoid vaccinations before the birth of their youngest child	Total number of mothers of children age 0-23 months in the survey	Baseline/Endline	78%	90%
	22	% of children ages 0-23 months whose births were attended by a skilled health worker	YES	Number of children age 0-23 months whose birth was attended by a doctor, nurse, midwife, auxiliary midwife, or other personnel with midwifery skills	Total number of children age 0-23 months in the survey	Baseline/Endline	64%	80%
	23	% of mothers of children ages 0-23 months who have discussed family planning with their husband	NO	Number of mothers of children 0-23 months who have discussed family planning with their husband	Total number of mothers of children age 0-23 months in the survey	Baseline/Endline	29%	80%
	24	% of children aged 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	YES	Number of children age 12-23 months who received a DTP1 at the time of the survey according to the vaccination card/child health booklet or mothers recall	Total number of children age 12-23 months in the survey	Baseline/Endline	71%	90%

Objective / Result	No.	Indicator	Rapid Catch Indicator	Numerator	Denominator	Frequency	Baseline Value	Target
	25	% of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	YES	Number of children age 12-23 months who received DPT3 at the time of the survey according to the vaccination card/child health booklet or mothers recall	Total number of children age 12-23 months in the survey	Baseline/Endline	66%	90%
	26	% of children aged 12-23 months who received measles vaccine according to the vaccination card or mother's recall by the time of the survey	YES	Number of children age 12-23 months who received a measles vaccination by the time of the interview as seen on the card or recalled by the mother	Total number of children age 12-23 months in the survey	Baseline/Endline	61%	80%
	27	% of infants less than 1 year old who were vaccinated at a vaccination clinic in the CHW catchment area (5km or less from CHW)	NO	Number of vaccinated infants less than 1 year old in the CHW's catchment area (5km or less from CHW)	Number of infants less than 1 year estimated to be in the CHWs catchment area (5km or less from CHW)	Quarterly	Pending	
	BCC Activities							
	28	# of health education talks given by the CHW	NO	NA	NA	Quarterly	223	488
	29	% of health education talks held	NO	Number of health education sessions held	Number of health education sessions planned	Quarterly	Pending	
	30	% of children under 5 who had a home visit from a CHW in the quarter	NO	Number of children under 5 who had a home visit from a CHW in the quarter	Number of children under 5 in the catchment area of the CHW	Quarterly	Pending	
	CHW Case Load							
	31	# of ORS packets distributed by the CHWs in the quarter	NO	NA	NA	Quarterly	70	152

Objective / Result	No.	Indicator	Rapid Catch Indicator	Numerator	Denominator	Frequency	Baseline Value	Target
	32	# of ACTs distributed by the CHWs in the quarter	NO	NA	NA	Quarterly	4130	9026
	33	# of LLINs distributed by the CHWs in the quarter	NO	NA	NA	Quarterly	215	469
	34	# of cases seen by the CHW	NO	NA	NA	Quarterly		
	Mutuelles							
	35	# of joint education talks with RAS/PROMUSAF/Mutuelle Network Partner	NO	NA	NA	Quarterly		
	36	% uptake in mutuelles	NO	Number of households enrolled in mutuelles in the project area	Total number of households in the project area	Annual	Pending	
3. Strengthened performance and sustainability of the community health delivery system	Knowledge and Skills							
	37	# of CHW supervisors trained in supervision techniques	NO	NA	NA	Quarterly		
	38	# of CHW trained in IMCI-C	NO	NA	NA	Quarterly		
	CHW Performance							
	39	Proportion (%) of children from 6-59 months treated for malaria	NO	Number of malaria cases treated in children 6-59 months	Number of malaria cases estimated in children 6-59 months	Quarterly	Pending	
	40	Proportion (%) of children from 2-59 months treated for diarrhea	NO	Number of diarrhea cases treated in children 2-59 months	Number of diarrhea cases estimated in children 2-59 months	Quarterly	Pending	
	41	Proportion (%) of children 2-59 months treated for acute respiratory infections (ARI)	NO	Number of ARI cases treated in children 2-59 months	Number of ARI cases estimated in children 2-59 months	Quarterly	Pending	

Objective / Result	No.	Indicator	Rapid Catch Indicator	Numerator	Denominator	Frequency	Baseline Value	Target
	42	Proportion (%) of children 6-59 months correctly treated for malaria according to national guidelines	NO	Number of cases of malaria in children 6-59 months correctly treated	Number of cases of malaria received in children 6-59 months of age	Quarterly	Pending	
	43	Proportion (%) of children 2-59 months correctly treated for diarrhea according to national guidelines	NO	Number of cases of diarrhea in children 2-59 months correctly treated	Number of cases of diarrhea received in children 2-59 months of age	Quarterly	Pending	
	44	Proportion (%) of children 2-59 months correctly treated for ARIs according to national guidelines	NO	Number of cases of ARIs in children 2-59 months correctly treated	Number of cases of ARIs received in children 2-59 months of age	Quarterly	Pending	
	45	Proportion (%) of referrals for malaria, diarrhea, ARI and malnutrition in children 2-59 months which were justified	NO	Number of cases of malaria, diarrhea, ARI, and malnutrition in children 2-59 months referred who presented with danger signs to the CHW and who were subsequently seen by a qualified health staff	Number of cases of malaria, diarrhea, ARI, and malnutrition in children 2-59 months referred by the CHW and who were subsequently seen by a qualified health staff	Quarterly	Pending	
	Supervision							
	46	# of MOH supervision visits received by CHW in the quarter	NO	NA	NA	Quarterly	Pending	
	47	# of monthly CHW meetings held	NO	NA	NA	Quarterly	Pending	
	48	# of PRISE-C coaching visits to CHWs by zone	NO	NA	NA	Quarterly	0	
	49	# of PRISE-C coaching visits to CHW supervisors by zone	NO	NA	NA	Quarterly	0	

Objective / Result	No.	Indicator	Rapid Catch Indicator	Numerator	Denominator	Frequency	Baseline Value	Target
	Sustainability							
	50	# of health zones with community health advisory board in place (at least 3 members)	NO	NA	NA	Annual	0	3

ANNEX 2: WORKPLAN OF ACTIVITIES

Activities October 1, 2011 to September 30, 2012

		Year 2			
		Q1	Q2	Q3	Q4
PROJECT MANAGEMENT					
	M&E training for Zonal data managers				
	Creation of M&E database				
	Regular Data collection				
	Identification of consultant for the midterm evaluation				
	Quarterly Meetings with USAID Mission				
Strategic Objective: To Accelerate the Delivery of Proven, Low-Cost Maternal and Child Health Interventions by Strengthening Community Health Delivery Systems					
IR 1 Increase Community Engagement with community health delivery system					
1.1	Create an enabling environment to community child health promotion				
1.1.2	Annual Community Development Action workplanning by Village Health and Development Committee (VHDC)				
1.1.3	Annual Village Health and Development Committee Meetings (every 6 months between the workplanning meeting)				
1.1.4	Execution of community development actions plans by VHDC and CHW (supported by CEID, BCC field agents and PRISE-C staff)				
IR 2: Increased demand for community preventive and curative services					
2.1	Improving knowledge, attitudes and practices towards child health				
2.1.3	IEC package training for Health Care Workers				
2.1.4	Provide IEC materials to Health Care Workers (from MOH/PISAF)				
2.1.5	BCC refresher training for CHWs and select womens group members				
2.1.6	Provide BCC materials to CHWs (from MOH/PISAF)				
2.1.7	Collaboration with other local partners to harmonize radio messages on maternal and child health				
2.1.8	Collaborate with mutuelles to ensure key messages for mothers on key practices for children's health				

2.1.9	Work with local women's groups theater to educate mothers on key practices for children's health				
2.1.10	Follow up BCC activities in the villages and health facilities				
2.2	Promote the uptake of mutuelle membership				
2.2.1	Discussions with community leaders to raise awareness about mutuelles and their services				
2.2.2	Facilitate the links between community and mutuelles organisations (PROMUSAF, RAS etc) for new mutuelle implementation in AZT				
2.2.3	Work to improve relations between facilities workers and members of mutuelles				
IR 3: Strengthen Performance and Sustainability of the Community Health Delivery System					
3.1	Improve functional programmatic support to CHWs by the Health Facility Workers				
3.1.3	Follow-up visits to health centers to assure proper supervision of CHWs				
3.1.4	Monthly Meetings of CHWs and health center supervisors				
3.1.5	Support for quarterly on-site supervision visits by CHW supervisors to CHWs				
3.1.6	CHWs Financial Incentive				
3.2	Reinforce the knowledge and skills of CHWs				
3.2.2	Integrated case management training for CHWs (AZT)				
3.2.3	Post training follow up				
3.2.4	On-the job refresher training on identified gaps in knowledge and skills				
3.2.5	Follow-up visits to CHWs to reinforce knowledge and skills				
Operations Research					
OR2	Receive feedback on the OR concept paper from the Comite d'Ethique in Benin for approval				
OR3	Formative research-initial phase (collection of socio-demographic data on CHWs and HHs, focus groups to determine final composition of QITs)				
OR4	QI methodology training				
OR5	Introduce collaborative in intervention zone-initial zonal collaborative meeting to identify priority health issues				
OR6	Baseline (Q1) and Routine data collection of CHW performance indicators				
OR7	Adaptation of CHW AIM tool				

OR8	First CHW AIM assessment				
OR9	In-depth interviews with a sample of hi/mid/low performing CHWs, VHDC members, CHW supervisors				
OR10	Quarterly Learning Sessions of Community level Collaborative in intervention zone				
OR11	Monthly QIT meetings at village level-CHWs and VHDCs in intervention zone				
OR12	Monitoring of OR activities in intervention and control zone by project staff and BCC field agents				

ANNEX 3: SOCIAL AND BEHAVIOR CHANGE STRATEGY

INTRODUCTION

PRISE-C's strategy for Behavior Change Communication (BCC) is intended to focus and guide the implementation of the project's communication approaches and activities aimed at improving maternal and child health in the community.

The key health needs of the population are reflected in USAID and PRISE-C's technical areas of focus. These focus areas are:

- Immunization
- Diarrheal Disease
- Pneumonia
- Malaria
- Infant and Young Child Nutrition
- Reproductive Health

PRISE-C will implement a multidimensional BCC strategy which will integrate complementary approaches to help providers, clients/parents, and communities to achieve the knowledge, attitudes, and behaviors required for improved health.

OBJECTIVES

The PRISE-C behavior change communication strategy has two main objectives:

- 1) Increase the number of CHWs who demonstrate appropriate communication and counseling skills
- 2) Increase the number/percentage of individuals and households who state correct knowledge of focus health issues and who practice the related health behaviors

STRATEGIES

To achieve these objectives, PRISE-C will:

- 1) Improve knowledge and skills of CHWs on BCC techniques and use of BCC tools
- 2) Improve knowledge and skills of care providers/CHWs supervisors on supervision of BCC activities
- 3) Improve the community's knowledge of positive health behaviors and increase their adoption

ACTIVITIES

Strategy 1: Improve the knowledge and skills of CHWs on BCC techniques and use of BCC tools

Activity 1.1: Train and monitor CHWs in BCC and Inter-Personal Communication techniques and on job aids/BCC tool

Training and on-site follow-up by project staff and CHW supervisors will improve the skills of CHWs in community-level BCC activities, which include home health visits, and community health discussion groups. Regular case management activities, which include a counseling component, will also benefit.

For this training and follow-up, PRISE-C will utilize a set of BCC tools that were developed and tested by the URC/CHS-implemented PISAF project that include counseling cards, provider job aids, etc. The job aids will be used by PRISE-C to aid BCC and Interpersonal Communication by health workers and CHWs, and the songs and theater pieces included with the tools can be used in community activities by CHWs, women's groups, traditional leaders etc.

Audience	Materials	Ideal Behavior
CHWs	BCC tools and training materials	Proper use of counseling cards and other BCC materials during home visit and group health discussions Activity reports on number of people reached, and number of community group engaged in BCC activities

Strategy 2: Improve the knowledge and skills of care providers/CHW supervisors on BCC activities supervision

Activity 2.1: Train and monitor health care providers in Inter-Personal Communication techniques and BCC activities supervisions

Training for health care providers, who are also CHW supervisors, will allow them to conduct informed supervision and assessment of CHW BCC activities. The supervisors will use the supervision tools developed by the MOH to assess the quality of each individual CHW's BCC activities. These tools include assessments by direct observation and a questionnaire for households visited by the CHW in the past week. After the assessment, CHW supervisors will support the CHWs to improve their application of their new BCC knowledge and skills.

Audience	Material	Ideal Behavior
CHWs Supervisors	BCC activities report BCC activities assessment tools Home visit validation tools BCC activities supervision tool	Correctly and thoroughly monitor CHWs use of BCC skills provide just in time (on the job) training Support the CHWS in implementation of new BCC knowledge and skills

Strategy 3: Improve the community's knowledge of positive health behaviors and increase their adoption

Activity 3.1: Coordinate the PRISE-C BCC activities with those of partners such as PSI and Africare, to ensure harmonization of activities and messages

We will collaborate with the Ministry of Health's technical working groups which are conducting mass media activities, such as PSI, the GFATM-funded malaria projects, UNFPA, and others who are supporting mass and traditional media to ensure that our activities complement each other and that key messages are harmonized.

Activity 3.2: Use targeted radio campaigns, regular broadcasts of radio and television, traditional media and entertainment approach - education (theaters, songs)

We will work with community radio stations to provide important health themes and content, such as correct technical messages, in local languages, both in written form and pre-recorded traditional media (already available from PISAF for SAO and DAGLA, to be developed for AZT)

Audience	Material	Ideal Behaviors
Mothers of children under 5 years Parents, particularly fathers, of newborn children	Radio: Songs, theater sketches	<p>Visiting the CHW for care-seeking and preventive counseling</p> <p>Immunization: Complete Immunization for children</p> <p>Diarrheal Disease:</p> <ul style="list-style-type: none"> Wash hands before and after critical actions Usage of a handwashing station with soap in each household ORS use for treatment of acute diarrhea Drinking pump water or water treated with aquatab <p>Pneumonia:</p> <ul style="list-style-type: none"> Care seeking for children with symptoms of pneumonia at the CHW or the health worker to provide a front-line antibiotic (CTX) <p>Malaria:</p> <ul style="list-style-type: none"> Sleeping under a treated mosquito net care seeking for the children with fever at the CHW or the health worker to receive ACT <p>Infant and Young Child Nutrition:</p> <ul style="list-style-type: none"> Breastfeeding during the first 24 hours of life Exclusive breastfeeding for the first six months of life Introduction of proper complementary foods <p>Reproductive Health:</p> <ul style="list-style-type: none"> Knowledge of danger signs (pregnancy, newborn or post-partum) First week of life consultation for newborns and postpartum women Knowledge of Family planning methods and where to access them
Pregnant women and their families	Radio: Songs, theater sketches	<p>Reproductive Health:</p> <ul style="list-style-type: none"> Attend at least 4 ANC visits and receive 2 IPT for malaria prevention before delivery Deliver at a health facility

Community leaders	Radio: Songs, theater sketches	Promote achievement of high immunization coverage by their communities as a matter of pride
Primary School Students	Radio: Songs, theater sketches	Identify newborn children, who are not immunized and encourage their families to take them to be immunized Pass on key health messages to their family

Activity 3.3: Neighbor-to-Neighbor health discussion groups led by CHWs in PRISE-C villages

Neighbor-to-neighbor activities are an innovation that will be introduced in Benin under PRISE-C. This approach uses social networking and triggered discussion to broadly and rapidly disseminate health messages within communities. Specifically, a trained leader (e.g. CHW, women's group or traditional leader) meets with five influential friends and briefly reviews a discussion trigger, usually a leaflet or an image on a counseling card. Each of the five friends receives five leaflets, and are asked to discuss them with five of their friends and give each of those five some of the leaflets to distribute, until a majority of households in the villages have discussed the leaflet or image. This approach, known as the "5-5 pyramid" was very successfully used by URC-CHS in Kenya¹ to change malaria treatment practices and is being used elsewhere as well. This approach will be tested in a specific geographic area.

We have a number of high-quality print materials that are already available for use either for counseling or for 5-5 pyramids. Some additional 5-5 images/leaflets will be developed by extracting key images and messages from counseling materials and printing them on inexpensive stock to be used as discussion triggers. This approach will link the images in the high-quality reusable materials to the images in the 5-5 leaflets, while being cost-effective. This approach is modeled on experiences with c-IMCI in Madagascar.

Audience	Material	Ideal Behavior
First wave of discussion groups:	Image/leaflets with key images and messages from counseling materials	Each member will meet with five influential friends and reviews their discussion trigger.
Community leaders, women's groups, existing community organizations	Counseling cards Brochures and other counseling materials	Each member adapts their behavior to the ideal health behavior discussed in the group
Subsequent waves of discussion groups: Mothers and fathers of children under five	Brochure/leaflet with images for discussion	Each member will meet with five influential friends and reviews their discussion trigger. Adoption of ideal health behavior discussed,

¹ Jirani Kwa Jirani study, Bungoma District Malaria Initiative project, URC-CHS/AMREF, Bungoma Kenya

		<p>which may be one or more of the following:</p> <p>Visiting the CHW for care-seeking and preventive counseling</p> <p>Immunization: Complete Immunization for children</p> <p>Diarrheal Disease:</p> <ul style="list-style-type: none"> • Wash hands before and after critical actions • Usage of a handwashing station with soap in each household • ORS use for treatment of acute diarrhea • Drinking pump water or water treated with aquatab <p>Pneumonia:</p> <ul style="list-style-type: none"> • Care seeking for children with symptoms of pneumonia at the CHW or the health worker to provide a front-line antibiotic (CTX) <p>Malaria:</p> <ul style="list-style-type: none"> • Sleeping under a treated mosquito net care seeking for the children with fever at the CHW or the health worker to receive ACT <p>Infant and Young Child Nutrition:</p> <ul style="list-style-type: none"> • Breastfeeding during the first 24 hours of life • Exclusive breastfeeding for the first six months of life • Introduction of proper complementary foods <p>Reproductive Health:</p> <ul style="list-style-type: none"> • Knowledge of danger signs (pregnancy, newborn or post-partum) • First week of life consultation for newborns and postpartum women • Attendance of 4 ANC visits for pregnant women • Promotion of delivery at a health facility • Knowledge of Family planning methods and where to access them
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KEY ACTORS

The PRISE-C team will work with the DDS and the Health Zone management team, service providers, COGECS, local elected officials, NGOs, social workers and religious and traditional leaders to carry-out these activities and achieve the stated objectives.

It will also build on mutuelle networks that are very active in the project areas, to ensure that health messages being discussed through those networks are correct and consistent.

Community organizations, such as COGECS, traditional artists, local radio, local associations, NGOs, and women's groups will play an important role in increasing knowledge, fostering supportive attitudes and encouraging wider behavior adoption by helping to implement interventions in BCC and to identify unmet needs for information.

MONITORING AND EVALUATION

PRISE-C BCC activities monitoring and evaluation will be based on routine project supervision and monitoring and evaluation activities. The strategy will be continuously assessed for areas which need improvement or strategies which need to be enhanced.

For Objective 1, increasing the number of CHWs who demonstrate appropriate communication and counseling skills, the quarterly supervision assessments of individual CHWs will be collected, including the assessment of BCC activities through direct observation and validation of household visits. Specific indicators from this assessment tool, such as “% of households visited in the past week where the head of the household can repeat the health message given to them by the CHW” will be monitored regularly.

Objective 2 of the BCC strategy will be assessed using the following indicators related to the ideal behaviors advocated through BCC activities:

Social and Behavior Change Strategy Related Indicators
Objective 2: Increase the number/percentage of individuals and households who state correct knowledge of focus health issues and who practice the related health behaviors
Source: Baseline/Endline Household Survey
% of children age 0-5 months who were exclusively breastfed during the last 24 hours
% of children ages 0-23 months with diarrhea in the last two weeks who were treated with ORS
% of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at a hand washing station
% of households who drink water from a pump or who treat their drinking water with Aquatabs
% of children aged 0-23 months who present with symptoms of pneumonia in the past 2 weeks and who received a front-line antibiotic (CTX) from a health worker or CHW
% of children age 0-23 who slept under a treated mosquito net the night before survey
% of children ages 0-23 with fever in the past two weeks who received ACT within 24 hours of onset of fever

% of children who received VitA in the last 6 months
% of mothers of children ages 0-23 who had at least 4 ANC visits when they were pregnant with their youngest child
% of mothers of children ages 0-23 months who had at least 2 VAT before the birth of their youngest child
% of mothers of children ages 0-23 months who received 2 IPTs before the birth of their youngest child
% of children ages 0-23 months whose births were attended by a skilled health worker
% of mothers of children ages 0-23 months who have discussed family planning with their husband
% of children aged 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey
% of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey
% of children aged 12-23 months who received measles vaccine according to the vaccination card or mother's recall by the time of the survey
% of mothers who know the CHW in their village
% of Mother who participated in the CHWs activities
% of Mothers who have interacted with the CHW in the past 2 months
Source: Quarterly CHW performance indicators
% of infants from 0-6 months who are exclusively breastfed
% of mothers ages 0-23 months who can name two danger signs (pregnancy, newborn or post-partum)
% of newborns seen by a health worker at least 2 times in their first week of life (1-3 days and 3-7 days)
% of children 6-59 months monitored for acute malnutrition
% of households with a handwashing station at/near latrines
% of households who drink water from a pump or who treat their drinking water with Aquatabs
% of children in the catchment area from 0-59 months who sleep under an LLIN
% of infants less than 1 year old who were vaccinated at a vaccination clinic in the CHW catchment area (5km or less from health facility)
% of children less than 1 year old who were vaccinated during outreach activities conducted according to the workplan in villages more than 5 km from a health center

ANNEX 4: OPERATIONS RESEARCH PROGRESS REPORT

Our operations research will test a community-based collaborative approach to quality improvement as an instrument for improving performance and retention of community health workers (CHWs). This research will compare two systems for motivating health worker performance: financial motivation and implementation of the collaborative versus financial motivation alone.

To date, organizations that work in the community with the community health workers have implemented different amounts of financial incentives to motivate them in their work. Recently, the government established guidelines for the financial motivation of the health workers. All the organizations that work in the community level are required to apply these guidelines that give the CHWs 10,000cfa (approximately \$20) per quarter and additional bonus up to 5,000cfa (approximately \$10) computed based on the assessment of the CHW on certain performance indicators.

During the operations research, two groups of CHW will be set up in two different health zones: Savè-Ouèssè (SAO) and Dassa-Glazoué (DAGLA). Both groups will receive the financial motivation as indicated in the Ministry of Health directives. Choice of the intervention zone will be made through a random drawing in front of community leaders and local ministry of health officials.

In the intervention zone, the quality improvement teams, which will be made up of CHWs, their supervisors and members of the village community health committee, and any other key decision makers in the community health structure (to be determined during formative research phase), will be oriented to the essential norms for providing healthcare for mothers and children at the community level. These norms are found in the Operational Plan for National Scale-up of High Impact Interventions (PIHI), prepared and adopted by the Ministry of Health in May 2010. These teams will identify common improvement objectives in the area of mother and child health. To achieve these objectives, each village, through its quality improvement team, will be required to test the changes whose results will be shared during quarterly learning sessions. The best practices that are identified during the learning sessions will be scaled up to all the other quality improvement teams in the health zone.

In the control zone, CHWs will receive regular supervision and financial motivation, with no participation in the collaborative.

PRISE-C's Operations Research protocol was written and submitted during this first year. The protocol was approved by USAID, and by URC/CHS's IRB. The protocol has been translated into French and submitted to the Benin Ministry of Health IRB for approval. Implementation will begin as soon as we receive this approval, ideally in October/November 2011.

Table 2: Operations Research Activity Progress Table

OR Key Study Milestones	Activity	Status	Comments
Preparation for initiation of study activities	Development of the protocol	Done	
	Submission of the Protocol to IRB (US and Benin)	Done	
	Approval of the Protocol	In process	US IRB approval has been received from URC/CHS's IRB, we are awaiting approval from Benin's IRB

ANNEX 5: RAPID-CATCH INDICATORS

Maternal Health				
% of mothers of children ages 0-23 who had at least 4 ANC visits when they were pregnant with their youngest child				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	260	264	207	731
Numerator	143	100	66	309
Percent	55.0%	37.9%	31.9%	43.2%
CI	8.6%	8.3%	9.0%	5.1%
% of children ages 0-23 months whose births were attended by a skilled health worker				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	300	296	296	892
Numerator	243	156	173	572
Percent	81.0%	52.7%	58.4%	65.8%
CI	6.3%	8.0%	7.9%	4.4%
% of mothers of children ages 0-23 months who had at least 2 TT before the birth of their youngest child				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	260	264	207	731
Numerator	202	220	148	570
Percent	77.7%	83.3%	71.5%	77.7%
CI	7.2%	6.4%	8.7%	4.3%
% of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	300	300	299	899
Numerator	261	285	246	792
Percent	87.0%	95.0%	82.3%	88.2%
CI	5.4%	3.5%	6.1%	3.0%
% of mothers of children aged 0-23 months who are using a modern contraceptive method				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	300	300	300	900
Numerator	12	18	17	47
Percent	4.0%	6.0%	5.7%	5.1%
CI	3.1%	3.8%	3.7%	2.0%

Vaccination				
% of children aged 12-23 months who received measles vaccine according to the vaccination card or mother's recall by the time of the survey				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	121	109	130	360
Numerator	73	75	73	221
Percent	60.3%	68.8%	56.2%	61.8%
CI	12.3%	12.3%	12.1%	7.1%
% of children aged 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	121	109	130	360
Numerator	93	79	85	257
Percent	76.9%	72.5%	65.4%	72.3%
CI	10.6%	11.9%	11.6%	6.5%
% of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	121	109	130	360
Numerator	85	76	77	238
Percent	70.2%	69.7%	59.2%	67.0%
CI	11.5%	12.2%	11.9%	6.9%
Malaria				
% of children in the catchment area from 0-59 months who sleep under an LLIN				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	300	300	300	900
Numerator	218	231	263	712
Percent	72.7%	77.0%	87.7%	78.2%
CI	7.1%	6.7%	5.3%	3.8%
% of children ages 0-23 with fever in the past two weeks who received ACT within 24 hours of onset of fever				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	58	80	36	174
Numerator	22	27	12	61

Percent	37.9%	33.8%	33.3%	35.3%
CI	17.7%	14.7%	21.8%	10.0%

Maternal Health				
% of mothers of children ages 0-23 who had at least 4 ANC visits when they were pregnant with their youngest child				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	260	264	207	731
Numerator	143	100	66	309
Percent	55.0%	37.9%	31.9%	43.2%
CI	8.6%	8.3%	9.0%	5.1%
% of children ages 0-23 months whose births were attended by a skilled health worker				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	300	296	296	892
Numerator	243	156	173	572
Percent	81.0%	52.7%	58.4%	65.8%
CI	6.3%	8.0%	7.9%	4.4%
% of mothers of children ages 0-23 months who had at least 2 TT before the birth of their youngest child				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	260	264	207	731
Numerator	202	220	148	570
Percent	77.7%	83.3%	71.5%	77.7%
CI	7.2%	6.4%	8.7%	4.3%
% of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	300	300	299	899
Numerator	261	285	246	792
Percent	87.0%	95.0%	82.3%	88.2%
CI	5.4%	3.5%	6.1%	3.0%
% of mothers of children aged 0-23 months who are using a modern contraceptive method				
	AZT	DAGLA	SAO	Weighted Aggregate

Denominator	300	300	300	900
Numerator	12	18	17	47
Percent	4.0%	6.0%	5.7%	5.1%
CI	3.1%	3.8%	3.7%	2.0%
Vaccination				
% of children aged 12-23 months who received measles vaccine according to the vaccination card or mother's recall by the time of the survey				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	121	109	130	360
Numerator	73	75	73	221
Percent	60.3%	68.8%	56.2%	61.8%
CI	12.3%	12.3%	12.1%	7.1%
% of children aged 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	121	109	130	360
Numerator	93	79	85	257
Percent	76.9%	72.5%	65.4%	72.3%
CI	10.6%	11.9%	11.6%	6.5%
% of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	121	109	130	360
Numerator	85	76	77	238
Percent	70.2%	69.7%	59.2%	67.0%
CI	11.5%	12.2%	11.9%	6.9%
Malaria				
% of children in the catchment area from 0-59 months who sleep under an LLIN				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	300	300	300	900
Numerator	218	231	263	712
Percent	72.7%	77.0%	87.7%	78.2%
CI	7.1%	6.7%	5.3%	3.8%

% of children ages 0-23 with fever in the past two weeks who received ACT within 24 hours of onset of fever				
	AZT	DAGLA	SAO	Weighted Aggregate
Denominator	58	80	36	174
Numerator	22	27	12	61
Percent	37.9%	33.8%	33.3%	35.3%
CI	17.7%	14.7%	21.8%	10.0%

ANNEX 6: PROJECT DATA FORM

Child Survival and Health Grants Program Project Summary

1.1.1 Oct-31-2011

**Center for Human Services
(Benin)**

1.1.2 General Project Information

**Cooperative Agreement
Number:** AID-OAA-A-10-00047

**CHS Headquarters Technical
Backstop:** Sara Riese

**CHS Headquarters Technical
Backstop Backup:** Sandrine Fimbi

Field Program Manager: Marthe Akogbeto

Midterm Evaluator:

Final Evaluator:

Headquarter Financial Contact: Sandrine Fimbi

Project Dates: 10/1/2010 - 10/1/2014 (FY2010)

Project Type: Innovation

USAID Mission Contact: Milton Amayun

Project Web Site:

1.1.3 Field Program Manager

Name: Marthe Akogbeto

Address:

Benin

Phone: (229) 96 22 78 48

Fax:

E-mail: makogbeto@urc-chs.com

Skype Name:

1.1.4 *Alternate Field Contact*

Name:

Address:

Phone:

Fax:

E-mail:

Skype Name:

1.1.5 *Grant Funding Information*

USAID Funding: \$1,749,780 **PVO Match:** \$437,445

1.1.6 *General Project Description*

The Center for Human Services (CHS), a 2010 Innovation category grantee, is implementing the *Partnership for Community Management of Child Health Project* in three of Benin's thirty-four health zones: Allada-Ze-Toffo, Save-Ouesse and Dassa-Glazoue. The project goal is to contribute to sustained improvements in child survival and health outcomes through innovations that reach vulnerable populations, which will be done by increasing community oversight and demand for high impact community preventive and curative services and strengthening performance and sustainability of the community health delivery system.

1.1.7 *Project Location*

Latitude: 7.35

Longitude: 2.07

Project Location Types:	Peri-urban Rural
Levels of Intervention:	Health Center Home Community
Province(s):	Atlantique and Collines Departments
District(s):	Allada-Ze-Toffo, Save-Ouesse, and Dassa-Glazoue Health Zones
Sub-District(s):	Allada, Ze, Toffo, Save, Ouesse, Dassa, and Glazoue Communes

1.1.8 Operations Research Information

OR Project Title:	Testing community level improvement collaborative to improve CHW performance and retention
Cost of OR Activities:	--
Research Partner(s):	CEID, Ministry of Health, Bureau of Statistics
OR Project Description:	The operations research (OR) component of the project will test whether the implementation of the community-level collaboratives improves community health worker (CHW) performance and retention as compared to the standard financial incentives and supervision structure for CHWs. In the intervention area, CHWs and members of the local village community health committees will form quality improvement teams and regularly assess progress on commonly identified priority health indicators and develop improvement plans for these indicators.

CHS postulates that three key aspects of the community-level collaborative (data-driven quality improvement methods, non-monetary incentives, and regular structured engagement of the community in the CHWs work) will lead to improved overall performance and retention of the CHWs.

1.1.9 *Partners*

Centre d'Expertise d'Ingenierie pour le Developpment Durable (CEID) (Subgrantee)	\$190,000
Africare (Collaborating Partner)	\$0
Catholic Relief Services (Collaborating Partner)	\$0
Benin Ministry of Health (Collaborating Partner)	\$0
Benin Department of Statistics (Collaborating Partner)	\$0
Réseau Alliance Santé (RAS) (Collaborating Partner)	\$0
Promotion des Mutuelles de Santé en Afrique (PROMUSAF) (Collaborating Partner)	\$0

1.1.10 *Strategies*

Social and Behavioral Change Strategies:	Community Mobilization Group interventions Interpersonal Communication
Health Services Access Strategies:	Community-based health insurance scheme/Community financing mechanisms Implementation with a sub-population that the government has identified as poor and underserved Implementation in a geographic area that the government has identified as poor and underserved

Health Systems Strengthening: Quality Assurance
 Supportive Supervision
 Monitoring CHW adherence with evidence-based guidelines
 Referral-counterreferral system development for CHWs
 Community role in supervision of CHWs
 Community role in recruitment of CHWs
 Community input on quality improvement

Strategies for Enabling Environment: Building capacity of communities/CBOs to advocate to leaders for health

1.1.11 Capacity Building

Local Partners: Local Non-Government Organization (NGO)
 Dist. Health System
 Health Facility Staff
 Government sanctioned CHWs

1.1.12 Interventions & Components

Control of Diarrheal Diseases (20%)	IMCI Integration	CHW Training
<ul style="list-style-type: none"> - Water/Sanitation - Hand Washing - ORS/Home Fluids - Feeding/Breastfeeding - Care Seeking - Case Management/Counseling - POU Treatment of water - Zinc - Community Case Management with Zinc (Implementation) - Community Case Management with ORS (Implementation) 		

Immunizations (20%)	IMCI Integration	CHW Training
<ul style="list-style-type: none"> - Polio - Classic 6 Vaccines - Vitamin A 		

Infant & Young Child Feeding (15%)	IMCI Integration	CHW Training
<ul style="list-style-type: none"> - Comp. Feed. from 6 mos. - Cont. BF up to 24 mos. - Maternal Nutrition - Promote Excl. BF to 6 Months 		

Malaria (10%)

IMCI Integration

CHW Training

- Training in Malaria CM
- Adequate Supply of Malarial Drug
- Access to providers and drugs
- ITN (Bednets)
- Care Seeking, Recog., Compliance
- IPT
- ACT
- Community Case Management of Malaria (Implementation)

Maternal & Newborn Care (20%)

IMCI Integration

CHW Training

- Recognition of Danger signs
- Newborn Care
- Post partum Care
- Child Spacing
- Birth Plans
- Emergency Transport

Pneumonia Case Management (15%)

IMCI Integration

CHW Training

- Case Management Counseling
- Access to Providers Antibiotics
- Recognition of Pneumonia Danger Signs
- Community Case Management with Antibiotics (Implementation)

1.1.13 Operational Plan Indicators

Number of People Trained in Maternal/Newborn Health			
Gender	Year	Target	Actual
Female	2010		
Female	2010		0
Male	2010		0
Male	2010		
Female	2011		35
Male	2011		53
Female	2012	15	
Male	2012	15	
Female	2013	0	
Male	2013	0	
Number of People Trained in Child Health & Nutrition			
Gender	Year	Target	Actual

Female	2010		
Female	2010		0
Male	2010		0
Male	2010		
Female	2011		35
Male	2011		53
Female	2012	15	
Male	2012	15	
Female	2013	0	
Male	2013	0	

Number of People Trained in Malaria Treatment or Prevention

Gender	Year	Target	Actual
Female	2010		0
Female	2010		
Male	2010		0
Male	2010		
Female	2011		35
Male	2011		53
Female	2012	0	
Male	2012	0	
Female	2013	0	
Male	2013	0	

1.1.14 Locations & Sub-Areas

AZT Health Zone	310,316
SAO Health Zone	213,443
DAGLA Health Zone	239,169
Total Population:	762,928

1.1.15 Target Beneficiaries

AZT Health	SAO Health	DAGLA Health	Total
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	Zone	Zone	Zone	
Children 0-59 months	7,175	3,827	2,724	13,726
Women 15-49 years	9,484	5,059	3,601	18,144
Beneficiaries Total	16,659	8,886	6,325	31,870

1.1.16 Rapid Catch Indicators: DIP Submission

Found in annex 5

1.1.17 Rapid Catch Indicator Comments

*For some indicators, there is a difference in the total number of mothers/children in the appropriate age group in the sample, vs the number used as the denominator. The reasons for this are:

Some data had to be taken from mothers' ANC cards, which not all women had available. In this case, the number used as the denominator was the number of women who had their cards available

Additionally, some denominators had missing data points, which were not included, and resulted in denominators slightly lower than the total sample.